COMMENTARY

The Advance of the Retail Health Clinic Market: The Liability Risk Physicians May Potentially Face When Supervising or Collaborating With Other Professionals

Christopher M. Burkle, MD, JD

The first retail health clinic opened in Minnesota in 2001 after the frustration a father, and future MinuteClinic cofounder, experienced during a long wait at an urgent care center for treatment of his son's strep throat.[1] CVS Caremark Corporation, the largest retail pharmacy in the United States, acquired MinuteClinic in 2006, further strengthening the foothold of retail health care clinics throughout the country. During the first 5 years, the industry added only 29 clinics before rapidly increasing by more than 10-fold between 2006 and 2008.[2] By 2008, the world's largest retailer, Wal-Mart, had also entered the retail clinic market, adding to the almost 1000 clinics at that time.[1] This accelerated trend reversed in 2009, reflected by the industry closing approximately 5% of outlets that year.[2] As early as 2007, significant future growth in the market was expected, with predictions of up to 6000 clinics by the end of 2012.[3] Despite this early optimism, as of June 2011, only a total of 1227 retail clinics are now in operation, slightly up from 1197 reported in February 2010.[2-5]

Although the overall profitability of these clinics has been questioned, recent health care reform efforts are forecast to increase consumer demand for retail health clinic services well into the future.[2,3,6] A combination of newly insured individuals after implementation of the Patient Protection and Affordable Care Act (PPACA) with an ongoing shortage of primary care physicians may lead to increased retail clinic use.[3] The difficulty in access to health care practitioners that the newly insured may experience has raised fears that they will seek future care in expensive emergency department settings.[2] A 2010 report exploring ways to reduce future health care costs in New York State argued that expanding access to retail health clinics could help reduce health care expenditures by $350 million between 2011 and 2020.[2]

To sustain economic viability, retail health clinic practice models largely rely on nonphysician practitioners to provide care. State regulations vary on the degree of physician oversight these practitioners require. With the predicted increased demand for care provided by retail clinics, the number of physicians who may be involved with supervising or collaborating with these practitioners will likely increase as well. Although no reported malpractice liability claim has been filed against a retail health clinic or their practitioners to date, physicians may find themselves at greater risk in the future. This commentary first describes the current financial and practice models in today's retail health clinic environment. This sets the foundation for exploring the potential future liability risk impacting physicians contracted to oversee the care provided in the retail health clinic sector.

Retail Health Clinic: Financial and Practice Framework

The employment model used by retail health clinics is unlike that observed under traditional urgent care clinic settings.[7] Typically staffed by physicians and other health care professionals, urgent care centers act as a "halfway house" between the emergency department and the physician's office.[7] In contrast, although some retail clinic settings may have physicians on-site, most have certified nurse practitioners as the primary providers of care.[7] Reasons suggested for the rapid increase in retail health clinics include overcrowded emergency departments, the increasing shortage of primary care physician ranks (estimated shortage of 40,000 family practice physicians by 2025), the impact that increased insurance costs have on patient access to physician clinics, and patient-consumer demands for improved convenience and affordability.[8] McKinlay and Marceau[9] reported that the decrease in the number of primary care physicians practicing in the United States will coincide with an increase in patients seeking care at retail clinics. By 2025, it is thought that many "everyday illnesses" will be managed by either patient access to self-help through the Internet or by nonphysicians practicing in retail health clinic settings.[9] In 2011, 100 separate operators managed a total of 1227 clinics existing in 42 different states.[4] When the retail health clinic market began at the early turn of the century, it was predominantly run by commercial retailers. More recently, traditional health care institutions have entered the market.[8] Although only 11% of the total number of clinics were owned and operated by health care organizations in 2008, this number had increased 60% (to

From the Department of Anesthesiology, Mayo Clinic, Rochester, MN.

Individual reprints of this article are not available. Address correspondence to Christopher M. Burkle, MD, JD, Department of Anesthesiology, Mayo Clinic, 200 First St SW, Rochester, MN 55905 (burkle.christopher@mayo.edu).

120 total clinics) in 2009 alone.[8] Despite the rapid influx of physician, hospital, and health care system–based entry into the retail clinic market, the overwhelming majority of clinics remain operated by retailers who own the building in which the clinic is located.[3]

In his 2010 article, Kaissi[8] argued that the fairly rapid increase in hospital-based ownership of retail health clinics was in part due to the desire for expansion and control of the path of referrals to their own employed physicians, hospitals, and emergency departments. Further adding to this spike was the growing concern that patients had for the qualifications of staff and the quality of care provided by retail clinics. Kaissi[8] stated that, by affiliating with hospitals that had traditionally been viewed as proponents of health quality and safety, some of these concerns voiced by critics of the quality provided by retail clinics might be allayed.

The commercial success of retail clinics is in large part driven by the degree of autonomy of care allowed nonphysician practitioners. Viable retail clinic profit models rely on nonphysician practitioners, predominantly nurse practitioners, who receive lower salaries and lower third-party reimbursement to provide more affordable care than might be delivered in an emergency department or urgent care clinic.[1,10] Thus, state regulations that impact nurse practitioner scope of practice and physician oversight requirements have been of great interest to retail clinic operators. For different reasons, physician organizations have fought for increased regulations impacting scope of practice and physician oversight of services.[1] Future profession-driven practice regulations and standards may influence the role that physicians undertake when accepting a supervisory or collaborative role. The American Academy of Family Physicians (AAFP) formulated a list of "desired attributes" for retail clinics, including a narrow scope of practice, an evidence- and team-based approach to care coordinated by physician involvement under a medical home concept, and appropriate use of physician referrals and electronic medical records to further continuity of care.[1] The American Medical Association (AMA) echoed many of the principles suggested by the AAFP, whereas the American Academy of Pediatrics (AAP) suggested that the fragmented care construct of retail clinics failed to support the medical home concept.[1] At odds to a degree, the American Academy of Nurse Practitioners (AANP) has suggested a "significant role" for nurse practitioners to include their full scope of practice within the retail clinic setting.[1] In the end, professional practice standards may help to form state regulatory boundaries of retail clinic practices and could in turn impact the degree of legal responsibility that physicians accede to in their supervisory or collaborative role. Debates over the quality of care provided by retail clinics, most often staffed by nurse practitioners, have been common. However, a 2009 study reported that the quality of treatment provided at retail clinics for 3 different conditions (urinary tract infection, otitis media, and pharyngitis) was equal to that in physician's offices and urgent care clinics, and was slightly better than that in emergency departments.[10] As of 2008, there had been more than 3 million clinic visits with 90% of patients rating their experience in several areas, including quality of care, as satisfactory.[11] Because of the expansion of retail health clinics across the United States, an increasing number of physicians have been approached to help serve in a supervisory or collaborative role. As of 2008, 11 states allow nurse practitioners to provide medical care independent of any physician involvement, 14 states require physician supervision, and 25 states mandate collaboration.[1,11,12] State statutes vary in the definition of physician supervision and collaboration.[13-15] Although neither supervisory nor collaboration requires physicians be permanently on-site, they must be easily contacted by telephone or available to visit the clinic for consultation or referrals.[14] At a minimum, all states mandating some form of supervision or collaboration require a "mutually agreed-upon relationship" between nurse practitioner and physician.[13-15] Topics that often are addressed in part or in full by these agreements are listed in Table 1.[13,14]

Physician Liability Concerns

One prominent medical malpractice insurer has reported a recent increase in the number of lawsuits involving nurse practitioners. This spike in frequency is thought to be primarily due to the increased number of advanced practice nurses employed today.[13,14] Among the possible other causes include the absence of proper policies and procedures, lack of written practice guidelines, inadequate physician supervision, failure of nurse practitioners to properly refer to or collaborate with a physician, and taking on excess clinical responsibility.[13,14] The risk of malpractice liability may worry physicians who contract to provide oversight (through supervision or collabora-

TABLE 1. Topics Addressed in Relationship Between Physician and Nurse Practitioner

Name of one physician in the collaborating or supervising role
Need for policies and procedures
Clinical coverage requirements for both the nurse practitioner and the physician
Practice guidelines, review of outcomes
Method of quality assurance
Scope of collaboration/supervision
Situations requiring immediate communication with physician
Record keeping and periodic review
Periodic visits to the practice site

tion) of nonphysician professionals. Although no reported cases of medical malpractice implicating the retail clinic itself, the nurse practitioners providing the bulk of care, or the physicians contracted to supervise or collaborate have occurred to date, such an event may be inevitable.[6] Two types of potential sources of liability for physicians working under such a retail health clinic arrangement may be of concern. The first is a direct liability resulting from a failure to meet the standards of supervision or collaboration with nurse practitioners. As such, it is imperative that before signing any contract, physicians become aware of, and are comfortable with their ability to meet, the requirements in their jurisdiction that speak to supervision or collaboration. A second potential risk to physicians is one of vicarious liability resulting from substandard care provided by the supervised or collaborating nurse practitioner. This type of liability may be the greatest fear given that many collaborative and supervisory agreements do not require continued on-site physician presence.[16]

It has long been described that an innocent party that shares a special relationship to another may bear the legal responsibility for the tortuous acts of the other.[17] The purpose of such an arrangement is said to help prevent future injuries, to ensure adequate compensation to injured victims, and to equitably spread losses caused by the related parties.[18] The care provided by nurse practitioners is governed by the laws of medical negligence.[19] Although negligent supervision claims may result from a physician's failure to follow requirements set out by state statutes, courts will more often apply the legal concepts of vicarious liability or respondeat superior to hold physicians liable after agreements to supervise or collaborate with nurse practitioners.[19] The concept of liability for another's acts after an agreement or relationship between parties is founded largely in the laws of agency. The Restatement (Third) of Agency states that "[a]gency is the fiduciary relationship that arises when one person (a "principal") manifests assent to another person (an "agent") that the agent shall act on the principal's behalf and subject to the principal's control, and the agent manifests assent or otherwise consents so to act."[20] Vicarious liability is born from the responsibility "that a supervisory party (such as an employer) bears for the actionable conduct of a subordinate or associate (such as an employee) based on the relationship between the two parties."[21] Respondeat superior is a form of vicarious liability that imparts liability on an employee, master, or principal for the negligent acts of their employee, servants, or agents.[19,21] Although the Restatement (Third) of Agency, case law, and legal commentaries typically restrict liability under respondeat superior to employer-employee relationships alone, some courts and legal commentaries, at times, have failed to adhere to this strict relational definition. Two elements must exist to find the physician liable under the doctrine of respondeat superior.[22] First, the employee, servant, or agent must perform the patient care duties in some type of a negligent manner.[22] Second, the element of physician control over that negligent party is decided by determining whether a master and servant relationship exists.[22] A physician's right to control the acts of another is said to be most important to the analysis of whether a master and servant relationship exists.[22] Although under traditional nursing practices physician control may have been more obvious, the degree of independence afforded nurse practitioners, other advance practice nurses, and physician assistants requires the supervising physician to clearly define the duties and responsibilities undertaken.[19] The courts themselves have often failed to provide a consistent explanation of liability in supervisory situations when reviewing unrelated cases.[21] This adds to the difficulty in predicting how this theory of liability would play out in supervisory and collaborative physician-nurse practitioner retail clinic settings. Although there is no "on point" legal precedent for such arrangements, several recent case law decisions involving physicians and their relationship with other health care professionals may offer some insight as to the variability and subsequent difficulty the courts have in defining what a right to control entails (Table 2). In reviewing the subsequent cases, the reader should be aware that case law decisions originating from one state do not hold the same degree of legal authority in other states. However, courts will often use holdings from other state courts to help guide previously non-adjudicated cases pending within their state.

The 2006 Alabama court decision in *Ware v Timmons* clarified that, for a supervising physician to be vicariously liable for the tortuous acts of those he or she is supervising, there must exist a consensual right on the part of both the supervisor to select who is being supervised and the subordinate to decide who the supervisor shall be.[23]

At the completion of a case involving an operation to repair an overbite suffered by a 17-year-old female, the nurse anesthetist paged the supervising anesthesiologist in preparation for extubation. Once the anesthesiologist arrived to the operating suite, the patient's endotracheal tube was removed. Monitoring equipment was then removed as she was transported to the postanesthesia care unit. On arrival to the postanesthesia care unit, the patient was reconnected to standard monitoring equipment, revealing that she was in cardiorespiratory arrest. Subsequent testing confirmed irreversible brain damage that eventually resulted in her death. The patient's estate filed a malpractice suit against the nurse anesthetist, the supervising anesthesiologist, and the employer of both parties. The prosecution's argument was that the nurse anesthetist's care during the postopera-

TABLE 2. **Vicarious Liability Case Law Involving Physician Supervision**

	Ware v Timmons 954 So. 2d 545 (2006)[23]	*Petzel v Valley Orthopedics* 770 NW 2d 787 (2009)[24]
Case history	At the completion of a case involving a 17-year-old female, the patient's endotracheal tube was removed by the nurse anesthetist with the supervising anesthesiologist present. Monitoring equipment was then removed in the operating room before the patient was transported to the post anesthesia care unit. On arrival, she was found to be in cardiorespiratory arrest, resulting in irreversible brain damage and eventual death.	With the help of a physician assistant (PA), an orthopedic surgeon performed surgery on the plaintiff's severely arthritic hip. At some point during the surgery, the plaintiff's sciatic nerve was damaged, resulting in partial paralysis of her foot.
Claim type	The patient's estate filed a malpractice suit against both the nurse anesthetist for care falling below the applicable standard of care required and the supervising anesthesiologist under the doctrine of respondeat superior.	The plaintiff sued both the physician and the PA. Included in the claim was vicarious liability of the physician for the actions of the PA through the legal theory of respondeat superior.
Court reasoning	Two elements must be met under the doctrine of respondeat superior— (1) both supervisor and subordinate voluntarily enter into the relationship and (2) the supervisor had a *right to control*, including the ability to select or dismiss the subordinate. The doctrine of respondeat superior does not pertain to situations in which supervisors and subordinates are working as coemployees because both a consensual relationship to work on behalf of each other and the supervisor's ability to select or dismiss the subordinate are missing.	Vicarious liability under respondeat superior typically arises in employer and employee relationships. It is not confined to this type of agency. The *right to control* is the determinative test for liability under the doctrine of respondeat superior regardless of the lack of an employer-employee relationship.

tive phase fell below the applicable standard of care required. Included in the plaintiff's claim was that the supervising anesthesiologist was vicariously liable, through invoking the doctrine of respondeat superior, for the negligent practice of the nurse anesthetist.

Referencing US Supreme Court precedent, the *Ware* court held that the principal-agent relationship intrinsic to a vicarious liability claim under respondeat superior requires both the voluntary control and the consent of both parties to act on each other's behalf. As part of the consensual relationship, the court interpreted the Restatement (Second) of Agency to require that the master must have the right to voluntarily choose—to select and dismiss—the alleged servant. As coemployees, each employee may consent to enter into a relationship with his or her employer, but there is no consensual agreement to a relationship to work on behalf of the other employee's behalf. Therefore, the court held that the doctrine of respondeat superior does not pertain to situations in which a supervisor, working as a coemployee, is vicariously liable for the torts of his or her subordinates. In the end, the court held that the plaintiff's claim against the supervising anesthesiologist would need to show that both elements of respondeat superior were met: (1) that both the nurse anesthetist and the supervising anesthesiologist had voluntarily (consensually) entered into the relationship and (2) that the supervising anesthesiologist had a right to control, including the ability to select or dismiss the nurse anesthetist. Although the *Ware* court stated that the right to control would not encompass a relationship between coemployees because of their lack of power to select and dismiss, other courts have not held the employer-employee relationship to be determinative. In the 2009 Wisconsin case of *Petzel v Valley Orthopedics*, an orthopedic surgeon, with the help of a physician assistant, had performed surgery on the plaintiff's severely arthritic hip.[24] At some point during the surgery, the plaintiff's sciatic nerve was damaged, resulting in partial paralysis of her foot. The plaintiff sued both the physician and the physician assistant. Included in the claim was vicarious liability of the physician for the actions of the physician assistant through the legal theory of respondeat superior. The trial court dismissed this claim after noting in part that, because the physician assistant was not an employee of the surgeon, no requisite master-servant relationship existed. The case was appealed to the higher court for review. The appeals court relied on prior case law from Wisconsin as well as its interpretation of the Restatement (Second) of Agency in finding that vicarious liability under respondeat superior, while typically arising in employer-employee relationships, is not limited to such situations. The court wrote the following:

> Vicarious liability under respondeat superior typically arises in employer/employee relationships but is not confined to this type

of agency. A servant need not be under formal contract to perform work for a master, nor is it necessary for a person to be paid in order to occupy the position of servant.

Instead, the court held that "the right to control is the dominant test in determining whether an individual is a servant" and the fact that an employer-employee relationship does not exist is not determinative. The appeals court remanded the case back to the trial court for a decision as to whether the facts, outside of a lack of an employer-employee relationship, supported the existence of a right to control prerequisite.

Although these 2 cases do not involve the nurse practitioner-physician retail clinic setting, the courts' reasoning may offer insight into the concerns and struggles faced when deciding a physician's liability exposure for the acts of another professional. Physician assistants and nurse anesthetists (practicing in states restricting independent practice) may be subject to greater physician oversight and involvement than required by state statutes regulating nurse practitioners. However, some argue that physician-nurse practitioner supervisory and collaborative agreements provide the requisite basis for the inference of a right to control.[19] According to the Restatement (Second) of Agency, a master-servant relationship is in part predicated on whether the 2 parties believe that they are creating such an affiliation.[19] However, the fact that the care provided by nurse practitioners is taking place outside the setting of the physician's office, with limited direct on-site physician involvement, and often billed separately through the nurse, it may counteract such a mutual belief.[19] Both the retail clinic financial framework and the practice model may influence the applicability and effectiveness of the goals set out holding physicians liable for the acts of other health care professionals. One of the functions of the legal theory of vicarious liability under respondeat superior is to ensure adequate compensation to an injured party.[19] The fact that many retail clinics are owned and operated by large commercial and health care entities, combined with the limited requirements for physician supervision and collaboration, may shift liability away from the overseeing physician and more toward reliable sources of "deep pocket" compensation.[19,25] A major goal of the tort law system in general is to limit the likelihood that similar negligent acts will recur in the future. By shifting liability away from the nurse practitioner and toward the supervising or collaborating physician, the beneficial effect on retribution and deterrence may be limited.[19] On the other hand, the ongoing efforts of professional health associations (AAFP, AMA, and AAP) to establish boundaries on the scope of practice and preferred requirements for physician oversight may shift legal responsibility to the supervising or collaborating practitioner employed in the retail setting.

Conclusion

Although no reported medical malpractice claim has been filed against practitioners working within the retail health clinic setting to date, this trend may not be sustained over the long term. If retail clinics gain in popularity as predicted by some, the number of patients cared for will likely continue to rise, thereby increasing the risk for physician liability. Furthermore, a heightened popularity among patients and practitioners combined with the lack of litigation to date may result in an expansion of the types of services provided by the retail clinic marketplace. Any increase in the complexity and acuity of illnesses managed in the retail health setting may lead to a parallel rise in the exposure liability.

Potentially impacting the future liability risks for physicians involved in the retail heath clinic market are the aggressive efforts of nurse practitioners to lobby state legislators for greater independence from what they view as restrictive supervisory and collaborative legislation.[19,26,27] Although these efforts may be continually resisted by physician organizations, if successful, over time physician liability may be mitigated as the degree of physician involvement lessens. On the other hand, if greater physician presence results from future legislation regulating retail health clinics, the heightened risk of medical liability may in turn follow.

What the retail health clinic litigation environment may look like for physicians in the future remains unknown. Will it involve direct liability in the way of negligent supervision or some form of vicarious liability? How would vicarious liability in the retail clinic setting be interpreted given the distant and rather independent nature of physician-nurse practitioner agreements? The first "test case" may offer some insight as to the responsibility that courts place on the supervising or collaborating physician. As corporate giants and large health care organizations own and operate retail health clinics, the role of physician liability as opposed to deep pocket enterprise liability may be better clarified.

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